VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF TOBACCO USE UPDATE 2004 SUMMARY BRIEF

What's New?

- More emphasis on population health
  - Focus on interventions that will have broad reach and help support all tobacco users' efforts to quit (I.E. emphasis on primary care-based treatment versus cessation programs
- Target population includes children, teens and young adults in a variety of medical settings to include primary care, pediatrics and dental clinics
- Includes a prevention pathway to address those who don't use tobacco and those who recently quit to stay tobacco free

What's New?Cont.

- **Format changes**
  - **Update provides clear objectives and direct recommendations in a behavioral format**
  - **Evidence is clearly presented in Evidence Tables and specific recommendations are formulated in a Recommendations Section**

Quality of Evidence (QE)

I: At least one properly done RCT

II-1: Well designed controlled trial without randomization

II-2: Well designed cohort or case-control analytic study

II-3: Multiple time series, dramatic results of uncontrolled experiment

III: Opinion of respected authorities, case reports, and expert committees

Overall Quality

Good: High grade evidence (I or II-1) directly linked to health outcome

Fair: High grade evidence (I or II-1) linked to intermediate outcome; or grade evidence (II-2 or II-3) directly linked to health outcome

Poor: Level III evidence or no linkage of evidence to health outcome

Grade the Recommendation

A: A strong recommendation that the intervention is always indicated and acceptable

B: A recommendation that the intervention may be useful/effective

C: A recommendation that the intervention may be considered

D: A recommendation that a procedure may be considered not useful/effective, or may be harmful

I: Insufficient evidence to recommend for or against - the clinician will use clinical judgment

Level A Recommendations

- **RECOMMENDATIONS WITH THE HIGHEST EVIDENCE: The highest evidence for recommendations is A, defined as "a strong recommendation based on randomized controlled trials that the intervention is always indicated and acceptable."**
  - **1. Patients should be asked about tobacco use at most visits, as repeated screening increases rates of clinical intervention. [R=A]**
  - **2. Tobacco users should be advised to quit at every visit because there is a dose response relationship between number of contacts and abstinence. [R=A]**

- **3. Physicians should strongly advise tobacco users to quit, as physician advice increases abstinence rates. [R=A]**
- **4. All tobacco users must have reasonable access to minimal counseling and to either an intermediate or intensive cessation program. [R=A]**
- **5. Cessation treatment should include the following components: • Tobacco use cessation pharmacotherapy [R=A]**
  - **Counseling techniques that have been shown to be effective (problem solving, skill training, intra and extra treatment support) [R=A]**
  - **Multiple treatment sessions [R=A]**
  - **Multiple formats, proactive telephone counseling, and group or individual counseling [R=A]**

- **6. Tobacco users who are willing to quit should receive some form of counseling. There is a dose response relationship between time spent in counseling and rate of abstinence. [R=A]**
  - **Minimal counseling (lasting <3 minutes) increases overall tobacco abstinence rates. [R=A] • Intensive counseling (>10 minutes) significantly increases abstinence rates. [R=A]**
  - **Multiple counseling sessions increase abstinence rates. [R=A]**
- **7. Effective counseling can be delivered in multiple formats (e.g., group counseling, proactive telephone counseling, and individual counseling) and may be more effective when combined. [R=A]**

- 8. Counseling should be provided by a variety of clinician types (physicians or nonphysician clinicians, such as nurses, dentists, dental hygienists, psychologists, pharmacists, and health educators) to increase quit rates. [R=A]
- 9. Tobacco users who are willing to quit may receive counseling via telephone Quitlines, as proactive telephone counseling has been demonstrated to be effective. Pharmacotherapy still needs to be coordinated by the primary care provider. [R=A]

- **10. Tobacco users attempting to quit should be prescribed one or more effective first-line pharmacotherapies for tobacco use cessation. [R=A]**
  - **First-line therapies include five nicotine replacement therapy (NRT) [transdermal patch, gum, nasal spray, lozenges, or vapor inhaler] and non nicotine replacement (bupropion IR or SR). [R=A]**
  - **Pharmacotherapy should be combined with minimal counseling (<3 minutes). [R=A]**

- 11. Health care providers in a pediatric setting should advise parents to quit smoking to limit their children's exposure to second-hand smoke. [R=A]
- 12. Adolescents who use tobacco and are interested in quitting should be offered counseling and behavioral interventions that were developed for adolescents. [R=A]
- 13. All patients admitted to hospitals should have tobacco use status identified in the medical record. [R=A]
- 14. Tobacco users who are older should be given advice to quit. [R=A]
- 15. Tobacco users who are older should be given tobacco cessation treatment, including medication and counseling. [R=A]

KEY ELEMENTS

1. ***Every*** **tobacco user should be advised to quit.**

2. **Tobacco use is a *chronic relapsing condition* that requires repeated interventions.**

3. **Several *effective treatments are available* in assisting users to quit.**

4. **It is essential to *provide access* to effective *evidence-based* tobacco use *counseling treatments* and *pharmacotherapy***

5. ***Collaborative tailored treatment strategies* result in better outcomes**

6. **Quitting tobacco leads *to improved health and quality of life***

7. ***Prevention strategies* aim at reducing initiation,**

VA/DoD Clinical Practice Guideline for Management of Tobacco Use

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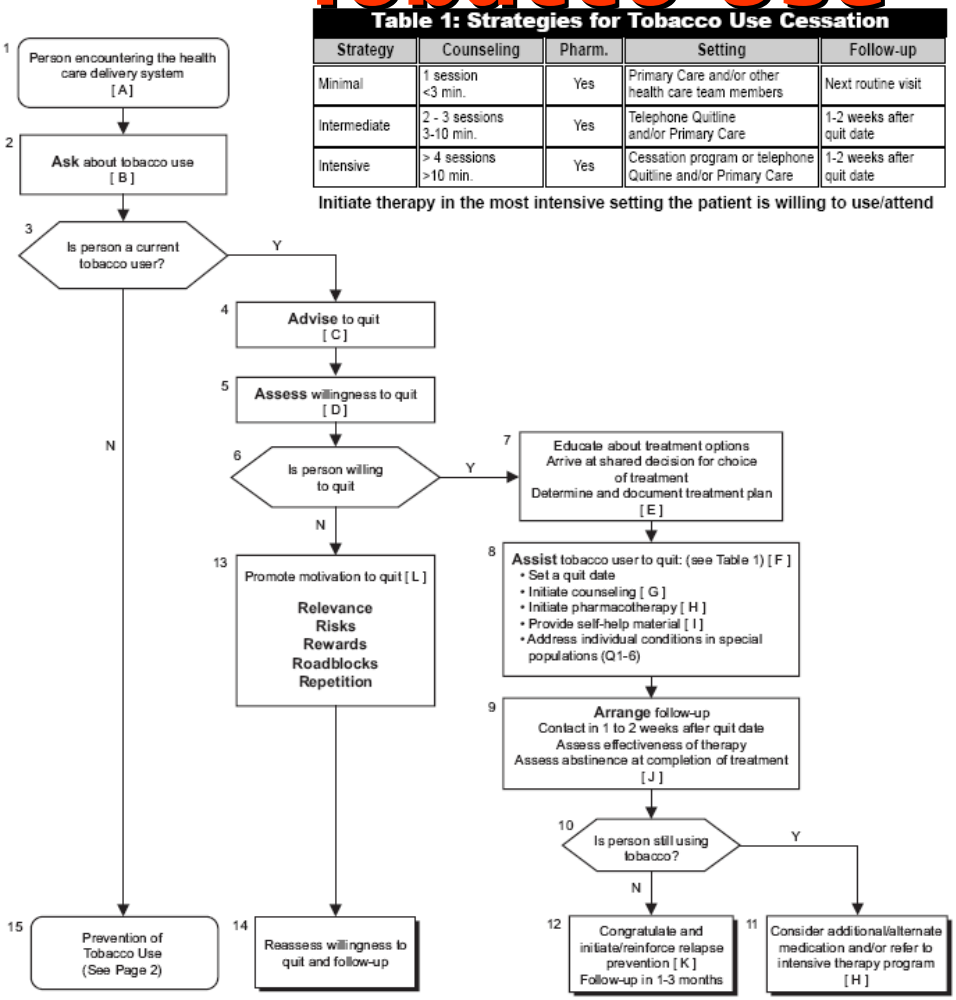

Table 1: Strategies for Tobacco Use Cessation

Strategy	Counseling	Pharm.	Setting	Follow-up
Minimal	1 session <3 min.	Yes	Primary Care and/or other health care team members	Next routine visit
Intermediate	2 - 3 sessions 3-10 min.	Yes	Telephone Quitline and/or Primary Care	1-2 weeks after quit date
Intensive	> 4 sessions >10 min.	Yes	Cessation program or telephone Quitline and/or Primary Care	1-2 weeks after quit date

Initiate therapy in the most intensive setting the patient is willing to use/attend

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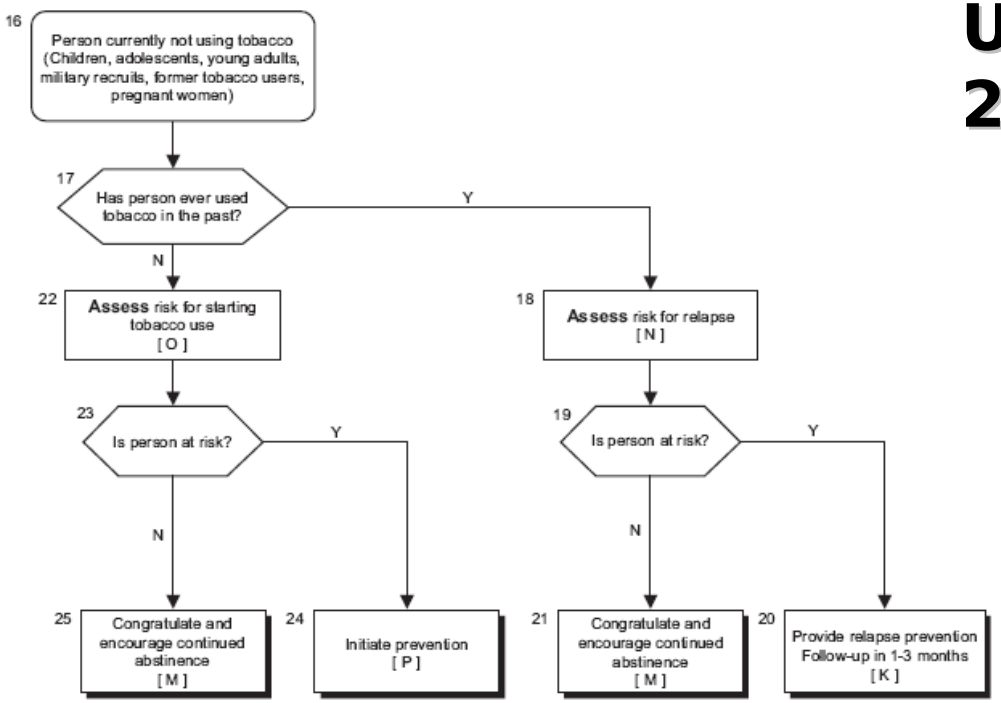
PREVENTION



Update, 2004

The Five A's

Getting Patients to Quit

- **Ask**
  Review tobacco use at every healthcare encounter
- **Advise**
  Strongly urge all tobacco users to quit
- **Assess**
  Determine willingness to quit
- **Assist**
  Help the tobacco user quit
- **Arrange**
  Schedule follow-up and relapse

The Five R's

Increasing Motivation to Quit

- **Relevance**
  Indicate why quitting is personally relevant
- **Rewards**
  Identify potential benefits of stopping tobacco use
- **Risk**
  Identify potential negative consequences of tobacco use
- **Roadblocks**
  Identify barriers or impediments to quitting and how to address them
- **Repetition**
  Motivational intervention should be

VA/DoD Clinical Practice Guideline for the Management of Tobacco Use Working Group Suggested Performance Indicators

- **Decrease number of *tobacco users***
- **Increase number of patients *screened* for tobacco use**
- **Increase number of patients *advised to quit***
- **Increase *documentation* of patient smoking status and treatment outcomes**
- **Increase *number of tobacco users enrolled* in treatment (e.g. prescribed pharmacotherapy)**
- **Increase level of *trained providers***

HEDIS PERFORMANCE MEASURES

- Percentage of patients advised to quit
- Percentage of patients who were recommended or discussed smoking cessation medications
- Percentage of patients who were recommended or discussed smoking cessation methods or strategies

ADDITIONAL RESOURCES

VA Access for Guidelines:
www.oqp.med.va.gov/cpg

DoD Access for Guidelines:
www.QMO.amedd.army.mil

The Surgeon General's Web Site:
www.surgeongeneral.gov/tobacco/default.htm

Tricare Management Activity's Website:
http://www.tricare.osd.mil/